DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 11/24/12

PRINTED: 10/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445276	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND VILLAGE CARE AND REHABILITATION CENTER	136 DAVIS LANE LAFOLLETTE, TN 37766

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure corridor doors closed to a positive latch. (NFPA 101, 19-3.6.3.) The findings include: Observation and interview with the Maintenance Director, on October 8, 2012 between 11:00 a.m confirmed corridor doors to residents room 327 and the central hall water heater room failed to close to a positive latch. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on	K 018 K 018	1. The latch on room 327 was fixed by the Maintenance Director to ensure that it closed to a positive latch on 10/12/12. The door to the central hall water heater room was fixed by the Maintenance Director to ensure that it closed to a positive latch on 10/12/12. 2. An audit of all doors in the facility was conducted by the Maintenance Director or designee on 10/19/12. No other doors were identified that did not close to a positive latch. 3. The Administrator conducted re-education with maintenance staff on ensuring all doors close to a positive latch on 10/19/12. 4. The Maintenance Director or designee will complete an audit of all doors weekly for four weeks and monthly for two months to ensure compliance is achieved and sustained. The Administrator or designee will review and analyze the results of the audit of all doors during the monthly Performance Improvement Committee for three months to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.	11/2/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/26/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	Continued From page 1 October 8, 2012.	K 018		
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure corridor fire doors were held open by approved devices. The findings include: Observation and interview with the Maintenance Director, on October 8, 2012 at 2150 p.m. confirmed the corridor fire door by the copy room had one side that failed to close to a positive latch:. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on October 8, 2012.	K 021	K 021 1. The corridor fire door by the copy room was adjusted by the Maintenance Director to ensure the door closed a positive latch on 10/8/12. 2. An audit of all doors in the facility was conducted by the Maintenance Director on 10/19/12. No other doors were found that did not close to a positive latch. 3. The Administrator conducted re-education with maintenance staff on ensuring all doors close to a positive latch on 10/19/12. 4. The Maintenance Director or designee will complete an audit of all doors weekly for four weeks and monthly for two months to ensure compliance is achieved and sustained. The Administrator or designee will review and analyze the results of the door audit during the monthly Performance Improvement Committee for three months to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.	

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K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to staff was familiar with fire drill procedures. The findings include: Observation during a fire drill conducted on October 8, 2012 at 2:45 p.m. confirmed the person discovering the fire failed to check the affected resident room and bathroom. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on October 8, 2012.	K 050	1. Immediate re-education was provided to the staff member not thoroughly checking the resident room by the Maintenance Director on 10/8/12. 2. Immediate re-education was provided to the staff members responding to the fire alarm regarding the necessity to completely check a room prior to leaving it and closing the door by the Maintenance Director on 10/8/12. 3. The Maintenance Director or designee conducted re-education with facility staff on ensuring the affected room during a fire drill is thoroughly checked by 10/26/12. 4. The Maintenance Director or designee will conduct fire drills at least once a month on various shifts for 90 days to ensure compliance is achieved and sustained. The Administrator or designee will review and analyze the results of the fire drills during the monthly Performance Improvement Committee for three months to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062	1. The dry system had a trip test performed by certified fire protection company on 10/17/12. The result of that trip test was 22 seconds. The leaks in the dry riser room were repaired by a certified fire protection company on 10/18/12. 2. An audit of both dry systems trip test were in the facility was conducted by the Maintenance Director on 10/17/12. Both	

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K 062	Continued From page 3 Based on record review, observation and interview, the facility failed to assure the sprinkler system was maintained. The findings include: Record review and interview with the Maintenance Director on October 8, 2012 at 3:30 p.m confirmed the last Dry system trip test conducted on 6-12-12 exceeded the 60-second time for water to reach the test outlet, by indicating it took 80 seconds. A second dry trip test was provided that was not acceptable due to incomplete and missing information. Observation and interview with the Maintenance Director on October 8, 2012 at 3:30 p.m confirmed the sprinkler riser room had leaks on a dry riser union fitting and the wet system upper control valve had a packing leak. The Maintenance Director stated that the valve had been repacked in the past year. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on October 8, 2012.	K 062	systems were within the appropriate range. An audit of the dry riser room was conducted by the Maintenance Director on 10/18/12. There were no additional leaks found. 3. The Administrator conducted re-education with maintenance staff on ensuring that trip tests are within the appropriate range prior to the departure of the contracted certified fire protection company and ensuring that the dry riser room remains leak free on 10/19/12. 4. The Maintenance Director or designee will complete an audit of the dry riser room weekly for four weeks and monthly for two months to ensure compliance is achieved and sustained. The Maintenance Director or designee will review the annual dry system trip tests to ensure continued compliance is sustained. The Administrator or designee will review and analyze the results of the dry riser room audit during the monthly Performance Improvement Committee for three months to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: NFPA 90A, 3-4.7 Maintenance - At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify	K 067	1. The fire dampers will be inspected by a certified contractor on 10/29/12. 2. An audit of all the fire dampers in the facility was conducted by a certified company on 10/29/12. 3. The Administrator conducted re-education with maintenance staff on	

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K 067	Continued From page 4 that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. Based on observation, interview and record review, the facility failed to assure fire dampers were maintained in accordance with NFPA 90A. The findings include: Record review and interview with the maintenance director on October 8, 2012 at 1:30 p.m. confirmed the facility failed to perform the 4-year required maintenance to fire dampers. The last fire damper inspections were done in 2007. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on October 8, 2012.	K 067	ensuring all fire dampers are inspected every four years on 10/19/12. 4. The Administrator or designee will review and analyze the results of the fire damper inspection during the monthly Performance Improvement Committee to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure the documentation indicated the emergency generator was run for 30 minutes under load each month. The findings include: Record review of the Emergency Generator logs with the Maintenance Director, on October 8,	K 144	1. The run hour meter will be replaced on 10/29/12 by the generator contractor. 2. An audit of the run meter on both generators will be conducted by the Maintenance Director on 10/29/12 to ensure they are functioning properly. 3. The Administrator conducted re-education with maintenance staff on ensuring the run hour meters are functioning properly on 10/19/12. 4. The Maintenance Director or designee will complete an audit of both run hour meters weekly for four weeks and monthly for two months to ensure compliance is achieved and sustained. The Administrator or designee will review and analyze the results of the run hour meter audit during the monthly Performance Improvement Committee for three months to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.	

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K 144	Continued From page 5 2012 at 10:00 a.m. failed to confirm when the Generator was run under load monthly. The run hour meter was not functioning properly in order to verify the generator was run for 30 minutes. Readings documented were 80.0 - 89.9 and then rolling back to 80.0. The generator was run weekly under load, for times ranging from .1 to .3 hours. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on October 8, 2012.	K 144		